Principals, agents or neither: a qualitative analysis of secondary care commissioning

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Draft paper prepared for HESG, 8-10 January 2003, University of Leeds

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Abstract: Government health policy has given PCTs a central role to play in commissioning secondary care from their NHS Trust providers.

An obvious perspective through which the relationships between PCTs and NHS Trusts can be viewed is the economist's principal-agent framework. PCTs, as principals, require the delivery of services to their patients, but do not own the facilities or have the expertise to deliver this care themselves, so contract with NHS Trusts, as agents, to provide these services.

The paper asks whether in fact PCTs are acting as principals and using Service Level Agreements (SLAs) to contract for services with their NHS Trusts as agents.

We report early results based on qualitative work with three case studies, each comprising a PCT and its main NHS Trust provider. Data were collected from observations of commissioning meetings and interviews with managers and clinicians from both PCTs and NHS Trusts.

Introduction

Government health policy has given Primary Care Trusts (PCTs) a central role to play in commissioning secondary care from NHS Trusts. Official documents describe one of the roles of PCTs as ‘commissioning secondary care services’ and lay out the framework within which PCTs and NHS Trusts should work (Department of Health 2002b; Secretary of State for Health 1997; Secretary of State for Health 2002). One of the mechanisms to be used in the commissioning process is the Service Level Agreement (SLA). These agreements were envisaged as a form of contract between PCTs and NHS Trusts. The profile of SLAs has been raised further in the recent paper ‘Reforming NHS Financial Flows’ (Department of Health 2002a) which outlines the use of reference costs for commissioning, and provides details on the content of a standardised SLA.

An obvious perspective through which the relationships between PCTs and NHS Trusts can be viewed is the economist’s principal-agent framework. PCTs, as principals, require the delivery of services to their patients, but do not own the facilities or have the expertise to deliver this care themselves, so contract with NHS Trusts, as agents, to provide these services.

This paper is based on early analysis of interviews with PCT and NHS Trust managers and clinicians. The paper asks whether in fact PCTs are acting as principals and using Service Level Agreements (SLAs) to contract for services with their NHS Trusts as agents.

The paper is structured as follows. Section 1 gives a brief summary of principal-agent theory and how this is mirrored by current government policy towards secondary care commissioning. Section 2 contains details of case studies and methods. Section 3 draws out interviewees’ perceptions of whether they are playing a principal’s or an agent’s role, and thoughts about the importance of SLAs. Section 4 asks what factors have helped in shaping these views and we conclude with a discussion of our current and emerging findings.

1 Principal-agent theory and government policy

Delegated choice involves one individual (the agent) having the responsibility for decisions that are in the interests of one or more others (the principal) in return for some form of payment (Arrow 1986; Rees 1985). As Ross (1973:134) indicates, a principal-agent relationship…

> *…has arisen between two (or more) parties when one, designated the agent, acts for, on behalf of, or as representative for the other, designated the principal, in a particular domain of decision problems.*

Problems associated with delegated choice form a large and important area for economic analysis (Rees 1985) and other disciplines (see Kiser (1999) for a review from political science and sociological perspectives).

As well as being in the interests of the principal, the agent's actions affect their own welfare. Differences in the objectives of the principal and agent, and information asymmetry, result in a challenge for the principal: to set payment schedules or devise other forms of incentives that encourage the agent to make decisions in the best interests of the principal. The use of agreements (or contracts) by one party to drive the performance and output of another is an integral part of principal-agent theory.

Principal-agent theory can be interpreted both normatively and descriptively (Arrow 1986; Rees 1985). Normatively, it can be used to illustrate the optimal forms of contract that should be devised under differing assumptions about the information available to or acquired by the principal or agent. Descriptively, it can be interpreted as an attempt to explain the characteristics of contracts actually observed between principals and agents in the empirical world.

Few applications of the principal-agent framework to the NHS have been normative. Levaggi (1996) is an exception. Most studies have used principal-agent theory descriptively to consider relationships in different sectors of the health care market, for example between purchasers and providers in the NHS (Goddard, Mannion, & Smith 2000; Sheaff & Lloyd-Kendall 2000; Smith et al. 1997).

This paper also adopts a descriptive approach. The original definition from Ross can be rephrased in the context of secondary care commissioning as follows.

A principal-agent relationship in commissioning has arisen when ***an NHS Trust****, designated the agent, acts for, on behalf of, or as representative for the* ***Primary Care Trust****, designated the principal, in* ***the provision of secondary care services****.*

Annex 5 of *'Reforming NHS Financial Flows'* (Department of Health 2002a) states that Service Level Agreements between PCTs and NHS Trusts should…

… clearly set out the understanding between commissioners and providers about all of the key dimensions of commissioning. With the shift of power and resources to PCTs, the SLA becomes a critical agreement for driving performance and change in service delivery. The SLA should also be the starting point for enacting financial flows and for setting out clear agreements about resources, activity, and risk.

Guidance on the use and content of SLAs, provided in Health Service Circulars, further strengthens the parallels between theory and policy.

Health Service Circular (HSC) 1998/198 discusses the allocation of risk (a key concept in principal-agent theory) between a PCT and NHS Trust. The suggestion is that the organisation that is able best to control risk should bear the financial consequences of such occurrences.

Activity Fluctuations and Risk Management. Agreements should apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event. The financial arrangements should reflect this.
For elective inpatient care, financial and clinical risk should be borne by the NHS Trust clinical and management team for the specialty or condition. (paragraph 16.4)

Later, HSC 1998/228 introduces the concept of incentives into SLAs, stating that they…

…will incorporate incentives for improving quality, cost effectiveness, and appropriateness together with clear responsibility for risk management, ensuring activity does not get out of kilter with funding. (paragraph 84)

The guidance given in these circulars has been reinforced recently in *Reforming NHS Financial Flows* (Department of Health 2002a). Here, the definition of commissioning includes specific reference to contracts, incentives and monitoring.

[Commissioning is a] continuous cycle of activities that underpins and delivers on the overall strategic plan for healthcare provision

> *and health improvement of the population. These activities include stakeholders agreeing and specifying services to be delivered over the long term through partnership working, as well as contract negotiation, target setting, providing incentives and monitoring.*

These excerpts from policy documents demonstrate clearly that one part of the government's policy for the NHS is to create contractual relationships between PCTs and NHS Trusts along the lines of principal and agent.

But what is happening in practice? Do PCTs consider themselves principals and NHS Trusts consider themselves agents? Are PCTs setting contracts designed to influence NHS Trusts' behaviour? It is these questions that this paper sets out to answer.

The closeness of PCTs to their main providers should mean that they are in a better position than health authorities to set and monitor such contracts. However, problems in measuring or specifying multiple outcomes, or both parties possessing very similar objectives, may mean that contracts are not considered important.

On the other hand, PCTs and NHS Trusts may not consider themselves principals and agents. If this is the case, the role of contracts is not immediately obvious.

2 Methods and description of case studies

Three case studies were considered. Each case study consisted of a PCT and its main NHS Trust provider for secondary care services. Case studies were chosen to reflect diversity in size, geography and financial context.

Size, defined by the number of practices in the PCT, was considered important for a number of reasons:

(a) A large PCT may be considered powerful due to its large share of an NHS Trust's services.

(b) A small PCT may be considered more powerful due to its flexibility in terms of shifting to alternative providers.

(c) A large PCT may be less able to represent the needs of all its member practices and offer a coherent policy to external organisations.

The geographical setting of each case study was different. Each comprised a different mix of urban and rural population. In addition, the market contestability of each varied. As well as diversity in private provision in the areas chosen, the availability of other NHS Trusts within a 30 minute travel time also varied[a].

Finally, financial context was considered important. The PCTs were chosen to reflect different levels from their 'target allocations' – that is, their equitable share of resources. NHS Trusts also had varied degrees of financial deficits, ranging from none to severe.

Table 1 shows the characteristics of each case study.

Table 1: Characteristics of the case studies

	Case study A	Case study B	Case study C
PCT size	medium	large	medium
Rural or urban	rural	urban	mixed
Alternative NHS providers?	yes	no	yes
Distance from target allocation	over	on target	under
NHS trust deficit?	no	yes	yes

Each case study held a series of meetings to agree the Service and Financial Framework (SaFF) for 2002/2003. SaFFs are documents that set out the services to be provided by an organisation and the resources available to the organisation to do so. SaFF meetings began in November 2001 and in some cases continued after the start of the 2002/2003 financial year. Up to five meetings in each case study were observed and written notes made. From May 2002, key players in these meetings were interviewed. The majority of interviews were tape recorded and transcribed verbatim. The initial set of interviewees were managers from the study PCT, the NHS Trust and where relevant neighbouring PCTs. Later, two consultant surgeons and two GPs from each case study were interviewed. These clinicians had not normally attended the SaFF meetings.

The table below shows the number and type of interviewees in each case study.

Table 2: Interviewees in each case study

	Case study A		Case study B		Case study C	
	NHS	PCT	NHS	PCT	NHS	PCT

[a] Propper (1996) found that less than 10% of hospitals had no competitor within a 30-minute travel time.

Directors/Heads of…	Trust		Trust		Trust	
Chief Executive	1	1	1	1		1
Finance	1	2	2	1	1	1
Operations/Commissioning			1	1	1	1
Clinician	2	2	2	3	2	2
Commissioning (nPCT)*				1		2
Regional Office						1
Total	4	5	6	7	4	8

** nPCT denotes a 'neighbouring PCT' involved in meetings with the same NHS Trust as the main case study PCT*

The areas discussed in the interviews were guided by topics considered important to agency theory. The topic guides included sections on interviewers' backgrounds, organisations' objectives, information availability and asymmetry, perceptions of roles, and monitoring. The software package Atlas.ti has been used for data management.

3 Perceptions of Commissioning and Service Level Agreements

This section gives participants' views of the commissioning process and associated procedures such as the SaFF process and SLAs, in an attempt to illustrate whether organisations are perceived, by themselves and others, as agents and principals, and indeed, whether they are acting in this way. The following descriptions are arranged by case study, beginning with details of the context within which each was working.

3.1 Case study A

There were no significant financial problems in case study A. In previous years, the health authority in case study A had stepped in to help reduce access times in its acute trusts, meaning that nationally, the acute trusts' access times were quite good, because locally, they had not been left to deal with the pressures of access targets by themselves ("nobody's ever been exposed" (meeting 5:28)). NHS Trust A had undergone a major improvement and expansion of its site before the Private Finance Initiative was introduced. As a result, the Trust was paid high capital depreciation costs by the health

authority to maintain its buildings, and had thus been sheltered from some of the pressures other Trusts were facing (from NHS Trust Manager 21:1).

NHS Trust A was located geographically within PCT A but was also the major provider of services to another PCT in the same health authority.

Two views on commissioning emerged from case study A. These appeared to be split along management/clinician lines rather than along PCT/NHS Trust lines. One view (predominantly from managers) was that commissioning in the sense that one party negotiated with another to deliver services no longer existed.

> *I mean in my view there is no such thing as commissioning, because basically what we're all here to do now is to deliver the NHS Plan. Commissioning implies some sort of negotiation and local interpretation. (HA Manager 23:93)*

Commissioning was considered a joint process of planning between PCT and provider (whether it be an NHS Trust or another PCT), with performance management playing an important role.

> *I would define commissioning now as a process where the community agrees a plan, the community then allocates responsibility for delivering it and then the community then has a performance system in place to make sure people do what they say they will do - to me that's commissioning. (HA Manager 23:80)*

> *…there are a variety of ways in which the SAFF process can work . . . [it] is about forecasting your costs, matching those or otherwise to funding streams and determining from that what you're able to achieve, . . . with an input from primary care in terms of their priorities and their participation in the health care delivery system. (NHS Trust Manager 22:1)*

> *…what we've got to actually do is ensure that we are delivering services on behalf of all our population. So, that's either in the terms of the primary care service is delivering those aspects that we need to deliver in primary care, . . . is [NHS Trust A] actually delivering in terms of the acute services and is [neighbouring PCT] delivering in terms of mental health. (PCT Manager 24:1)*

The SLA was seen as more of a 'direct accountability agreement' than an incentive based contract.

The Service Level Agreement is then a more detailed expression of that agreement [the SaFF], in terms of a direct accountability agreement between one organisation and another, so it would basically put the requirements of what that organisation is expected to deliver. (HA Manager 23:4)

The SLA gave no details about how agreed activity was to be delivered or paid for.

Respondent: But, you know, to me, if you've got a target and the NHS plan says that orthopaedic operations should be done to 6 months by the 31st March so and so, you know, that writes the Service Level Agreement for you. The only big issue for discussion is well, how do you do it? But the Service Level Agreement is very clear.
Interviewer: Do those "how do you do it" things go into the SLA?
Respondent: No, no. (HA Manager 23:53)

The other view (predominantly from clinicians) was that PCTs were (or could be) in control, and as such playing a principal's role.

… the surgeons do not appreciate what potentially is the importance of Primary Care Trusts to their own work, the commissioning of their work. It hasn't sunk in at all.
Interviewee: Importance in terms of…?
Respondent: Well, what I would call control, influence, those sorts of things. A driver, you know, we want this done. It's control and influence are the probably the two aspects to call it. (NHS Trust Clinician 84:5)

I mean in a simple way, basically, it was sort of about 'you have the service, we need the service, how can we best look at how it can be provided and how does the finance work?' That's really the simple way, the way we're looking at it. (PCT Clinician 35:11)

Views appeared divided over the importance of SLAs. One view was that their importance was…

Huge, because activity is our biggest thing and a lot of our money depends on us achieving our activity targets, which is fine, as long as it's achievable. (NHS Trust Clinician 84:6)

The other that SLAs had no teeth.

… I've been through so many years with these kind of agreements and quite a lot of the time they're not worth the paper that they are written on, so in other words, if an agreement is not adhered

to what happens? The tradition has been that there has been very little under that to pin it down. It's nothing new, I've been saying this for years. (PCT Clinician 35:56)

There was an recognition that commissioning could go down two potential routes: the 'business relationship' or the one with 'fuzzy' edges.

What we tried to do as a PCG, and then moved… and are trying to do as a PCT actually… is a bit more as Blair came out with some time ago, you know, more, you know, a little bit, making it a bit more fuzzy, discussing and supporting, rather than a business relationship and there's a canyon between you. (PCT Clinician 35:18)

If there was a principal in case study A, it was the health authority, with the PCT and the NHS Trust both acting as its agents.

Our pressure actually doesn't come from the PCT, again it's the strategic health authority that's saying these are the rules. The PCT does what it's told in relation to us. It's a front organisation (laughs) at the moment, for the health authority. (NHS Trust Clinician 84:1)

An SLA for 2001/2 between the PCT and the NHS Trust in case study A did not exist. Instead, the SLA was between the HA and the NHS Trust.

Up until now it's been the HA with the Acute Trust. What we want to try and move to is this concept that it's joint. (PCT Manager 24:71)

In summary, the health authority in case study A appeared to be the principal, with SLAs being used as part of the performance management framework and of little significance in terms of providing incentives for activity.

3.2 Case study B

NHS Trust B was in financial deficit and struggling to meet some access targets. The NHS Trust and a number of PCTs met on a regular basis to agree the SaFF and, at the same time, to discuss issues related to modernisation. NHS Trust B was located within PCT B, and was a major provider of services to an additional two PCTs in two health authorities.

In case study B, the PCT tended to be seen as, and act as, the principal, having the final say in the commissioning process, but did not utilise SLAs as part of the process. Instead, the NHS Trust took the lead in developing the SLA, which was used as an internal NHS Trust performance management document.

Both PCT and NHS Trust respondents were clear that the PCT had the final say in commissioning decisions.

> *Certain individuals in the PCT take the line, well, you know, we are now the commissioners of your service! (laughs) We have the money and we tell you what to do with it! That's the way it's going to be, get used to it. (NHS Trust Manager 28:76)*

> *I suspect everybody is struggling to come to terms with the fact that the PCTs are now the [commissioning body]. ... (laughs) We say you're going to do this, you can do it! (PCT Manager 27:31)*

> *In, in the early days there was a view that nothing would change, of late, mainly due to attendance at regional meetings for chairs, it has become quite obvious that PCTs are now the drivers. (PCT Clinician 29:20)*

> *The PCT is there to commission and meet the health needs of the local population. So we'll always be trying to do things in consultation and through negotiation with [NHS Trust B] and indeed our own services but there will come a point that we are actually the commissioners, so we can stand back from the debate and make a decision about how we're going to spend our resources, and what style and how many services that we want. (PCT Manager 33:4)*

Compared with the 'old style' of purchasing, new style commissioning was seen as more collaborative and driven by health need. Although the perception of egalitarianism and a whole health community approach were strong, the PCT managers were very aware that they held the commissioning purse strings…

> *It doesn't have the same connotations and tone it had when it was called a purchaser/provider split because the whole political ethos then was about 'if you don't give us what we're asking for as purchasers, we're going to move up to Fife' or wherever. So I think the whole language set is different, but maybe that's just a way of masking the reality because we're all into collaboration and so on. But when you peel all of that away, the bottom line is we still purchase services. (PCT Manager 33:102)*

The NHS Trust, however, did not believe that their role was solely as an agent for the PCT. They preferred to take a more active part in the commissioning process and to visualise the organisations as equal partners.

> *… when I'm discussing issues with colleagues from the PCT, we are doing it on the basis that we have a joint interest in getting this sorted out and we're just looking for the best option that exists for resolving the issue. I don't sit there thinking I'm looking for the best thing from the Trust's point of view anymore than I think they're sitting there saying what's the best option from the PCT's point of view. We're looking at the most effective solution to a problem. (NHS Trust Manager 28:80)*

Although playing the principal's role, the PCT could see the benefits of the NHS Trust's involvement. There was a view that commissioners were strengthened by, indeed almost dependent on, the provider's expert knowledge, and also that in some cases, the appropriate commissioner was in fact the provider.

> *They are equals in the commissioning process because often the answers to commissioning issues come from the consultants. The people who have to have a lot of the vision for resolving commissioning issues are actually in the provider organisations because they have the real expertise. So, somehow, although we are perhaps commissioning with the money and I hope we bring other skills as well, you know, it's not a one sided relationship. (nPCT Manager 34:27)*

> *That's an interesting one because I said to [commissioning director] when it happened, I said why aren't you the one who is commissioning those extra services, that would be what people are expecting. In practice and in pragmatically, we found it was easier to allow [NHS Trust B] to have the money and do it because of the organisational thing, it's quite interesting. The consultants were all- for example, the operations director is better placed to do the negotiations with the consultants about which cases go away and which are the sensible ones, if it's all kept internally to the organisation, rather than for them to have this perception that it's being done to them by the commissioning organisation. Although technically it's a bit odd, because they'll be commissioning about £1.5m of service this year from private hospitals and maybe other NHS hospitals. (PCT Manager 26:46)*

Respondents from both organisations claimed to lead in the development of SLAs, but the predominant view was that the NHS Trust did so, primarily because the SLA acted as one of their internal performance management documents.

> *… most of what constitutes the Service Level Agreements at the moment are actually our performance management plans that we have at the moment that I mentioned earlier which are developed by our performance management development department here. (NHS Trust Manager 83:4)*

> *I think in the past [NHS Trust B] has led because then that's their sort of internal agreement with each of their directorates and we sign it off with them. (PCT Manager 33:107)*

Some respondents found the fact that the NHS Trust took the lead a little strange.

> *It's unusual as I understand it for provider Trusts to be drafting service agreements. (NHS Trust Manager 28:48)*

> *… it covers a great pile of paper about that thick which is mainly written by the hospital, which sounds slightly odd to me. Shouldn't it be mainly written by commissioners? I don't know!(PCT Manager 34:109)*

The general view appeared to be that the SLA was a detailed 'contract specification', but also used as a 'mechanism of agreement'.

> *The Service Level Agreement is normally a speciality or client group specific and it is a contract specification which says this is what we will do for this amount of money to this quality standard with these governance issues, with these access targets met etc, so that is very precise and much more as a contractual arrangement. (NHS Trust Manager 31:5)*

> *It's all about exclusions and terms and conditions and monitoring requirements, all of those sorts of things. (PCT Manager 33:107)*

> *The SLA then puts the flesh on those bones [of the SaFF] and just sews up what you are actually getting for the investment and how it will be monitored. (PCT Manager 26:5)*

> *Service Level Agreements are generally an expression of the SAFF and they're annual plans for services so they describe the quantity and, when it can be described, the quality of services to be delivered. They're mechanisms of agreement, they're*

mechanisms to say well this is what you agreed to do(NHS Trust Manager 83:2)

Others were less kind, claiming that SLAs were very short and not detailed (from PCT Clinician 29:35) or that…

… it has an awful lot of words in it and quite a lot of numbers. (nPCT Manager 34:109)

It's like job descriptions. A good job description you actually get out of the drawer to see what are you meant to be doing. I think a Service Level Agreement should be like that and I don't think they are. (nPCT Manager 34:108)

Having SLAs at all was not viewed as essential. The purpose of the SLA was not necessarily the end product, but the discussions and solutions that arose out of agreeing it.

I suppose at the end of the day they could not sign it. They could sign it and not do the thing that they don't like. … I think it's unlikely that we would want to put anything in there that they wouldn't like or that we can't resolve. … I mean, that was- let's face it, that was part of the problem with the internal market. All these blinking quasi contracts when at the end of the day they were meaningless because you can't go to law on it and let somebody else thrash it for you. You've got to keep going until you get the issues resolved. (PCT Manager 26:47)

I'm not totally convinced that that is distilling out the absolutely, the really important things. Are we just slightly going through the motions? If we didn't have it, I'm not sure we've signed last year's yet. I mean we've got it, I'm not sure it's actually been done. If it's not rigorously enforced... I suppose it serves some function but I'm slightly doubtful, I can't really energise myself to take it that seriously unless we can turn it into something different which really works for us and that people look at because it's helpful. (nPCT Manager 34:110)

In summary, there was a strong feeling from both the PCT and the NHS Trust in case study B that the PCT were the final decision makers in terms of commissioning, but there was a parallel belief that the process should take on board the needs and desires of the whole health community, and that the provider had an important role to play. Both organisations saw the SLA as an agreement pertaining to the activity, finance and quality of services to be delivered, although its current usefulness as a contract between the PCT and NHS Trust was disputed.

3.3 Case study C

NHS Trust C had a large financial debt and was struggling to meet many access targets. The financial deficit made the organisations feel as if they were starting from a position behind everyone else.

> *… we did achieve our financial targets but obviously there has to be- we didn't do that without help and the accounts are supposed to show a true and fair view of the finances of the organisation and we need to record that we [had a] bail out. And that's great for last year but it doesn't help us in the new financial year. (NHS Trust Manager 37:8)*

> *I think that we had a group of primary care organisations, one that was a PCG and 3 that were PCTs, but clearly with very different ways of working but trying to come together to undertake one of the most, well a fairly difficult piece of negotiation, with a Trust that was in financial crisis. (NHS Trust Manager 39:13)*

The NHS Trust was situated within PCT C and was a significant provider of services to an additional three PCTs in two health authorities.

Responses are characterised by confusion over what constituted commissioning, and in particular, who was undertaking the commissioning.

> *Well I think the first problem is you have to define commissioning. I think we're in a period of change, I think commissioning maybe five years ago had more of a focus on purchasing and contracting and now has a focus on planning and development. (PCT Manager 32:1)*

> *I think it's quite simple. You look at the population, what's their health need, what do they need, what in the way of service to meet their health need and where do you find it from. And that's commissioning, and then how do you ensure it's delivered. (Regional Manager 80:92)*

> *… you could just say here's your cost and you go – [NHS Trust C Ch Exec] – you go develop what you want, so long as you live within it, but I don't know how [NHS Trust C Ch Exec] would then prioritise between the digital hearing aids, the macular degeneration and everything else. That seems to me that it's a commissioning role. (nPCT Manager 38:21)*

The NHS Trust respondents expected the PCTs to take the lead role in commissioning and were confused and frustrated that this was not happening.

> *PCTs should be responsible for commissioning health care*
> *(NHS Trust Manager 39:117)*

> *…discussions are becoming very frustrating because no-one is agreeing to give us more money and I have never, ever been involved in a SAFF process which is such a shambles before.*
> *(NHS Trust Manager 37:13)*

At the time of the interviews, the PCTs were not taking the lead, the NHS Trust was taking a lead role in the commissioning process, a lead role that they were not expecting to have to take.

> *…in frustration we're currently sort of setting out our understanding of the position and we're going to send it to the PCTs and tell them, these are the figures that we're working to, this is the money that we're going to spend. But I've never been in a situation where I've had to take that initiative before because before, the discussions that we've had have produced agreed tables, agreed spreadsheets about how things are built up, how the money's coming. (NHS Trust Manager 37:19)*

The PCTs, however, wanted to work collaboratively with the NHS Trust, having a firm belief that commissioning was about health community partnerships, not PCT leadership.

> *The idea that the commissioner is in charge is silly (PCT Manager 32:134)*

> *We consider commissioning to be what goes on in spite of the SAFF, if you like, in the Service Development Groups where we expect the real important business of commissioning, i.e. developing care pathways, developing an outcomes approach to service delivery in partnership with the provider. (PCT Manager 36:3)*

The purpose of the SLA was equally unclear.

> *There must be a distinction! SLAs and SAFFs can be terms that are used interchangeably, but the SAFF is the Service and Financial Framework and I guess, maybe you can correct me if I'm wrong, is there a right or wrong answer? … I don't know. … I don't know. You might have an SLA with a small organisation which isn't necessarily included… I don't know, I don't know. Sorry. (nPCT Manager 38:3)*

Respondents suggested that SLAs were not important or perhaps did not exist.

> *… they're just a document. They're pieces of paper. … I'm not quite clear what the purpose of a Service Level Agreement is anymore. It was all- it's a hangover from the days of contracting.* *(PCT Manager 32:50)*

> *I have to say, as regional office we asked for Service Level Agreements and nobody anywhere ever provided them for us, it's not just a [case study C] thing. So I've never seen one, I don't know what they've got. I don't entirely believe that they exist because they never shared them.* *(Regional Manager 80:63)*

In contrast, there were some quite specific ideas about what SLAs ought to include.

> *A Service Level Agreement to me is their contracting arrangements between- so it's everything historically plus whatever was agreed in this year's SAFF round becomes a Service Level Agreement.* *(Regional Manager 80:63)*

> *The Service Level Agreements should be an expression of the Service and Financial Framework on a specific organisation basis.(PCT Manager 36:2)*

In reality, there was confusion and lack of implementation.

> *… we have no agreement on the funding, we have no agreement… we have no Service Level Agreements in place with our commissioners. I don't think we've probably ever really put together proper Service Level Agreements which have been monitored. (NHS Trust Manager 39:16)*

> *I don't think, although I could be wrong, that a Service Level Agreement document between the [NHS Trust C] and PCTs exists* *(nPCT Manager 38:88)*

In summary, the views held in case study C differed between the NHS Trust and the PCT. The conflict was between the PCT's plan for partnership and the NHS Trust's view that the PCT was failing if it did not take the lead role. SLAs, if they existed, were not used as a means to influence behaviour.

4 Shaping beliefs

The previous section has shown some diverse views about commissioning and SLAs. This section shows the main issues that have shaped respondents' views. The first two issues (context and tradition) relate in the main to commissioning styles. The following three factors are those that respondents felt lessened the importance of SLAs. They are the national 'must do' issues, timescales and accountability structures.

4.1 Context - "an incredibly complex environment"

Context played a role in case study A by making the PCT and NHS Trust very relaxed about getting involved with commissioning, and case studies B and C very concerned.

A positive local context appears to be an important factor that has influenced the organisations' lack of involvement in commissioning in case study A. As a result of cushioning by the health authority, NHS Trusts and primary care services in this area were quite comfortably off and disinclined to become involved in implementing change.

> *It's actually [HA area A]'s quite laid back. On the whole, general practice in [HA area A], people are fairly happy, it works quite well, I think on the whole give a pretty good service and don't have the sort of problems you might get in the middle of Bradford, and so there is less incentive, I think, for people to feel they need to get involved anything. It's a reps. graveyard [HA area A]! ... There's not really the feeling, the need to- "why should I get involved, I only get involved when something seems to happen that affects me", you know. (PCT A Clinician 35:64)*

The context in case studies B and C was different. In both, there were multiple PCTs (three in B and four in C) working with NHS Trusts with financial deficits. The two case studies approached their similar contexts in different ways.

In case study C, there was a perception that problems had been created by having a large number of commissioners at different stages of development.

> *I think it was fairly chaotic. And I think it was chaotic for a number of reasons. There was a huge amount of organisational change in the system. [NHS Trust C] had a particular problem of being, at the time, split between three health authorities ... and the component PCTs in that there are four PCTs that they have to work with to develop that process. And all the organisations are*

at different stages of development with different remits.
(Regional C Manager 80:7)

I also think that [PCT C] are far more developed and I think that's from the way [HA C] behaved. [HA C] was very much a delegator and empowerment of their PCGs and PCTs, whereas I still think in [adjacent HA] there was an element of "we're in control" – the health authority – and then suddenly the PCGs had to get on with it and found it probably very difficult, working in an incredibly complex environment. (NHS Trust C Manager 39:46)

The previous section showed case study C characterised by confusion about commissioning and a perceived lack of leadership. There was a belief from NHS Trust C that working with one commissioner would solve many problems.

…my view is that we need one lead commissioner to make this happen. One lead person working with the [NHS Trust C] to agree what it is on behalf of. (NHS Trust C Manager 39:69)

Within case study B there were not the same concerns despite there being three PCTs from two health authorities, with the PCTs at different stages of development. Case study B had taken the decision that each PCT would lead with NHS Trust B in the commissioning of one broad clinical area, for example, PCT B led on surgical services.

During the SaFF process, the predominant view was that the whole health community was in financial trouble, not just the NHS Trust, and so the whole health community should work together to improve the situation.

I was concerned that we, as a community, don't dig ourselves in too deeply or we at least don't make things worse - because as you know we've inherited a lot of mortgaging from previous decision making. (PCT Manager 26:4)

The community divided its new resources for 2002/3 proportionately between the organisations, making each organisation responsible for meeting its own targets from this financial envelope. This system looks different to that which we might expect from commissioning through SLAs, but it was felt to be appropriate for case study B at that time.

In case study C, the situation appeared less structured, with the NHS Trust deficit overshadowing the whole process. The PCTs had not agreed a united front. These

circumstances were perhaps made worse by the fact that the different PCTs presented their finances in different ways.

> *... the way that [neighbouring health authority] presents the figures is different from the way that [PCT C] presents them. So you feel that you're sort of adding up apples and oranges and then you have convert the oranges back to apples.* *(nPCT Manager 38:84)*

4.2 Tradition - "that's the legacy of the health authority"

Tradition impacted in two ways: a continuation of systems used by health authorities and a continuation of actions for acquiring funding by the NHS Trusts.

Of the three case studies, A is the only one where the PCT and the NHS Trust did not meet face to face to agree the Service and Financial Framework for 2002/3. This was carried out by the health authority and appeared to be the way that the process had always been carried out.

> *I think it is now beginning to change. Once, no, I see the signs of a structure being put in place where it will have to change. But it hasn't impacted yet, because it was old mode last year – the old mode. It may be different.* *(NHS Trust A Manager 22:62)*

The health authority leadership in A was a strong driver, becoming a tradition in itself.

> *In terms of [HA A] we've had a driver who is the same driver and has been the same driver since I've been here, almost ... the process has been identical.* *(NHS Trust A Clinician 84:9)*

The impact of the traditional system in B was different. Here, the approach was considered by some to have become too cosy, detracting from the real job of commissioners in ensuring treatment for patients. This may account for the belief in 'B' that although a whole health community approach was beneficial, the PCT still had the final say.

> *... I think that's the legacy of the health authority and a very unhealthy one. And that's part of this thing I was saying right at the beginning about is it all sort of too collaborative and too cosy and so on and that is re-enforced by this block contract thing*

where the money flows whatever, whether the patients are treated or not. *(nPCT Manager 34:38)*

Both case studies B and C noted the tradition of NHS Trusts in putting together bids for funding new developments. This allowed the NHS Trusts to bypass the PCTs, thus weakening their commissioning roles. Particularly in NHS Trust C, the leaders appeared to have a 'forgetful' attitude when it came to requesting resources from the PCT, an issue that may show why there was some confusion over an obvious structure for commissioning in this case study.

Certainly I think they [the PCT] do need to get to grips with the planning of services and capacity requirements. In fact what's tended to happen over the years is that was resources tended to build up in the NHS Trusts ... because they have, devote more- certainly locally they devote far more management resource to actually working up bids for more money and looking for opportunities. *(NHS Trust B Manager 26:17)*

... earlier in the year . . . [Dir of Finance] brought a draft... I can't... it might have been like a template for what a business plan would have on it or new development would have on it, and it didn't have on it... you know, it had where the Chief Exec. would put his signature and who, what general manager had done the business plan and it had on it what the costs were and everything, but it didn't have on it anywhere where the PCOs would actually sign off their approval, which I just thought that demonstrated that here was a senior manager from the [NHS Trust C] who forgot the processes, that the organisations that are commissioning are supposed to approve the new developments. *(nPCT C Manager 38:20)*

4.3 Time pressures - "it comes down to timescales"

SLAs are the final document of a whole string of commissioning related documents to be produced, and can only be produced after the SaFF has been agreed. As a result, PCTs have had little time and energy left to develop detailed SLAs.

... over the SaFF process period, because it was so pressured by the [NHS Trust C], they could only just focus on the real key issues. *(nPCT C Manager 41:4)*

... if things were kicked off a bit sooner then we could look at things like that [using reference costs] in more detail. *(nPCT C Manager 41:74)*

… we thought well we [the PCTs] ought to be getting together to agree our common front sometimes without them [the NHS Trust], but we hardly ever meet. We were meant to have a meeting of that this week but when we had the main meeting everybody had to rush off and we never got round to it. I think we will drift apart if, take… we might be more active in taking forward the per-case agenda than them, really. I'm slightly concerned about that, that we don't have enough time to get our commissioning act together. (nPCT B Manager 34:26)

I think again it comes down to timescales. . . . I think the reality is though that to get things done to the timescale we've tended to drive things more… (HA A Manager 23:53)

4.4 National 'must do' issues - "everybody is really only aiming at national targets"

By far the biggest driver for both NHS Trusts and PCTs were the national 'must do' priorities. These are the NHS Plan targets and the NSFs. These were felt to be such strong drivers that devising SLAs either to strengthen the drive or change its direction appeared pointless.

Many appreciated the clarity of direction and standards provided by the national agenda.

… with the publication of the NHS Plan, there are very, very clear targets that organisations have to deliver now. (HA A Manager 23:7)

… there is a strong target approach and that is the driver behind all this. (PCT A Manager 24:25)

… if one looked, I don't know, at coronary heart disease, and the role that we have to play in treating people with coronary heart disease, in the early 1990s you sat, you could sit down, scratch your head and say I wonder what standards of provision we ought to be aspiring to and ensuring that we meet? … now we've got a national set of standards and frameworks that set out what we ought to be aspiring to. … It's made it a lot clearer. (NHS Trust A Manager 22:9)

We've got service groups in 16 areas, so who makes the decision between the areas? Now actually a lot of that is taken out of our hands because the government's very clear about what the next five priorities are – cancer, coronary heart disease, mental health, access and you know, can't remember the fifth, older

people. So we know what our priorities are. (PCT C Manager 32:12)

The general view was that if the national targets and standards were dictating what should be achieved, why should the organisations spend limited management time devising duplicate agreements?

> *And I think where we're being helped there is, to be honest, it's all being done nationally now anyway, so there's no point in us having a separate set of indicators.(PCT C Manager 32:108)*

> *… clearly the NHS Plan is, in the last – what, since it came out in July 2000 – it has played an enormous part in sort of setting the direction of travel. We know what the acute trust objectives are, we know which elements of the NHS Plan we've got to deliver, and we've got to develop, deliver a process or design a process that gets us from A to B in order to deliver those. (Regional Manager C 39:27)*

> *You've got an NHS Plan so really most of the Service Level Agreement writes itself from the NHS Plan. (HA A Manager 23:53)*

4.5 Accountability - "we have those which are P45 issues"

Control and influence by organisations that were higher up the NHS hierarchy were considered important drivers. NHS Trusts are not accountable to PCTs. It was the health authorities and the regional offices that had the real power to influence commissioning decisions. In discussing the final stages of the SaFF process, this PCT manager describes the strength and role of the regional office.

> *The regional office came back with a letter which had nine things on it which were all the access targets and said 'okay, these are the things that you really must do, and we want you to get financial balance'. So it's that process of gradually testing out what we've done, and we all reacting, and then testing the strength of your reaction and whether it's real or not, and then pushing you to see how far back you'll move, and then finally boiling down to that, which is one letter with nine key targets. (NHS Trust B Manager 26:10)*

The penalties for not achieving targets didn't come from SLAs, but from higher up the NHS organisational hierarchy, in the form of threats to job security.

> *... at the end of the day, what's my role in relation to the [NHS Trust C]? Say it had a nil star rating. So what am I supposed to do about it? Well, (a) I can't sack the Chief Executive because that will done nationally. (PCT C Manager 32:109)*

> *Obviously we have those which are P45 issues, such as we're not allowed to breach the over 15 month targets, we're not allowed to breach over 26 week waits. These are national things and they're non-negotiable, they're sacking- P45s are sacking offences. (NHS Trust B Manager 31:7)*

> *We get asked about once a quarter on how we're doing on single sex accommodation but it's not something that the Chief Exec.'s going to get a phone call from Nigel Crisp about, you know, and that's, I think, the categorisation. (NHS Trust C Manager 28:9)*

NHS Trusts' accountability to regional offices was used to effect action. One PCT had a small number of patients about to breach the waiting time targets for outpatient treatment at one of its own community hospitals. The consultant due to see these patients belonged to the local NHS Trust. Negotiating directly with the NHS Trust to get the patients treated had no impact. The PCT then turned to the regional office.

> *I just put in my returns the reason why we were going to have long waiters was because they were waiting to see a consultant who was employed by [NHS Trust C] and funnily enough that did trickle down so [NHS Trust C] did eventually in late March offer those patients appointments... (nPCT C Manager 38:96)*

When the accountability ladder works like this, it is not surprising that PCTs don't feel the need to have their own SLAs.

To conclude, the result of these national pressures was that the PCTs and the NHS Trusts were 'in it together'.

> *We're in it together, if you like on the- we both are going to get a lot of flack for not balancing the books. (NHS Trust B Manager 28:13)*

What I think ultimately, although SaFF discussions are very hard work, there is a sense in the end that the health community lives or dies together... *(NHS Trust B Manager 83:49)*

Whilst these views predominate, it is perhaps unlikely that PCTs are going to use SLAs to influence or hold to account NHS Trusts. The national framework needs to change if PCTs are really going to be empowered and take on the role of principal.

To a large extent, the powers that be in the NHS have not sufficiently held PCTs to account for this [NHS Trust performance], in my opinion. So, if a hospital is failing to achieve waiting times or something, they would visit the hospital and give them a good kicking. Actually, perhaps they ought to come and visit us and give us a good kicking. I'm silly to want that but until that sort of accountability route is established, we're just going to say that's you're problem and get on with it, we've got some other things to think about. *(PCT B Manager 34:87)*

5 Discussion

This paper has used qualitative methods to investigate the commissioning process, viewed through a principal-agent framework. Results show that PCTs can visualise themselves in a principal's role but a parallel belief in working with providers across the whole health community may be weakening this function. Similarly, NHS Trusts do not see themselves as passive agents reacting to contracts set by PCTs, but as part of the decision-making body on behalf of the health community.

We would expect that if SLAs were considered a tool for influencing hospital provision, that they should contain incentives and rules for how to deal with in-year risks. Instead, we have shown that SLAs are not taken seriously at this stage, although some believe that they have potential for the future. There are other issues that may affect beliefs about the use of SLAs that we have not had time to analyse yet in full, but the main issues appear to be the overwhelming need to deliver the national targets, and an accountability structure that does not mirror the commissioning structure. It may be that until PCTs are given the freedom to incorporate local priorities in the commissioning process, the purpose of SLAs with NHS Trusts will remain uncertain. Whilst the strongest priorities and levers remain at the level of 'higher' principals (i.e. at national or health authority level), it is understandable why SLAs are not used to their full potential.

Dixit (2000) reviews recent developments in the theory of incentives between principal and agent, and draws out some important issues for delegated choice in the public sector. These include multiple principals and hierarchies. This paper has shown how multiple PCTs are an issue in case study C, but has looked at only one set of relationships: those between PCTs and NHS Trusts. One of the issues at this stage of the analysis that may become increasingly important is the relationship between the management and clinicians, within both PCTs and NHS Trusts. When the critical choices on service delivery are made by clinicians *within* organisations, the purpose of setting SLAs *between* organisations can be questioned. It may be that multiple and hierarchical tiers of relationships are shown to be most important: that is, the important principal-agent relationships are those between managers and clinicians, and between Strategic Health Authorities and the PCTs or NHS Trusts that they host.

Issues that we will be looking at in the future include the following: conflicts of interest for PCTs of being both commissioners and providers; the difficulties of reconciling a contract negotiating and setting role with partnership working; the perceived lack of choice of provider and resulting dependency of both PCT and NHS Trust on each other; views about information sharing and information asymmetry; and issues around the interplay between incentives, monitoring and 'micro-management' of NHS Trusts by PCTs.

The findings presented in this paper are based on early analysis of a sample of interviews. The emphasis in the findings may change as more interviews are included and new issues explored. The majority of interviews included to date are from managers. The majority of those not yet included are from clinicians.

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